



Proton Pump Inhibitor Prior Authorization Form Fee-for-Service Medicaid/PeachCare for Kids PHONE #: 866-525-5827

FAX #: 888-491-9742

Note: If the Following Information is NOT filled in completely, correctly, or legibly the PA process **can** be delayed. **(One form per member please)**

MEMEBER Last Name MEMBER First Name						
MEMBER ID nu	mber MEMBER Date of Birth					
PRESCRIBER L	ast Name PRESCRIBER First Name					
PRESCRIBER N						
PRESCRIBER	4F1#					
PRESCRIBER F	Phone PRESCRIBER Fax					
PRESCRIBER A	Address	1				
Medication Requested:Strength						
DirectionsDosage Form Compound Y N						
Duration of Therapy Requested						
Diagnosis-Indication – Please do not include documentation that is not requested on this form.						
Please (circle which indication/diagnosis that applies to member:					
a.	Barrett's Esophagus					
b.	b. Peptic Ulcer Disease (PUD)/ Duodenal ulcer/ Gastric ulcer					
	c. Erosive Esophagitis					
d	d. GERD without complications					
e.	GERD with complications- please					
	specify:					
f.	H. Pylori					
g.	g. Zollinger Ellison (ZE) Syndrome					
h.	h. Pancreatitis					
i.	Cerebral Palsy					
j.	Cancer					
k.	Crohn's Disease					
I.	Multiple endocrine adenomas					
m	. Systemic mastocytosis					
n.	n. Patient was recently discharged from the hospital (within the last 60 days) for an upper GI bleed,					
	hemorrhage, perforation, or obstruction and was already started on PPI therapy in the hospital					
	o. Gastric Bypass Surgery					
Other Diagnosis/Complicated Disease State						

nz receptor antagomst us	e mstory.		
Drug	Strength	Directions	
Dates used: from	to	Failed due to:	
Drug	Strength_	Directions	
Dates used: from	to	Failed due to:	
Physician Signature:			
Contact Person			

SXC Health Solutions, Inc. will provide a response within 1 business day upon receipt.

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